PFR First Grantee Leadership Training Kick-Off Meeting

May 13-15, 2014
Hyatt Regency Newport Beach
Welcome

Rosemary Chalk, Doris Duke Charitable Foundation (DDCF)
Lola Adedokun, Doris Duke Charitable Foundation (DDCF)
Phil Redmond, The Duke Endowment (TDE)
Nancy Young, Children and Family Futures (CFF)
Opening Remarks

Rosemary Chalk, DDCF
Doris Duke Charitable Foundation
Mission Statement

The mission of the Doris Duke Charitable Foundation is to improve the quality of people's lives through grants supporting:

• The performing arts
• Environmental conservation
• Medical research
• **Child well-being**
• Preservation of the cultural and environmental legacy of Doris Duke's properties.
The mission of the DDCF Child Well-Being Program is to promote children’s healthy development and protect them from abuse and neglect.

During her lifetime, Doris Duke frequently supported individual programs to assist troubled children, youth, and families, often through anonymous grants.

See more at: http://www.ddcf.org
**MISSION:**
To promote children’s healthy development and protect them from abuse and neglect.

**GOAL**
Build a more robust repertoire of prevention strategies

**GOAL**
Expand capacity of existing systems

**GOAL**
Develop and disseminate knowledge

- **Place Based Approaches**
  - Boston Medical Center
  - Children’s Bureau of Southern CA
  - Children’s Outing Association
  - Common Ground Communities
  - Meta House
  - Teachers College

- **High-Risk Situations**
  - Fund for Public Health in NY
  - Children and Family Futures

- **Broader Audience**
  - CDC Foundation
  - Chapin Hall
  - Harvard University
  - Zero to Three
History of the Grant to CFF

• Identification of substance use as a key risk factor for child abuse and neglect

• Early awareness of CFF role in providing training and technical assistance to Family Drug Courts (FDCs)

• Recognition of the uneven quality of parenting programs and children’s services in FDCs

• Identification of pioneering efforts to improve developmental services for various dependency courts (i.e., Miami Court model, Safe Babies Program organized by ZERO TO THREE)
History of the Grant to CFF

- Recognition that various courts are testing the use of diverse evidence-based parenting interventions with support from the HHS/RPG and other grants
- Opportunity to develop integrative and system-wide practices that highlight parent-child relationships and child well-being indicators within the FDC and to evaluate the challenges associated with such efforts
Key Features of the CFF Proposal

• Identify evidence-based parent training approaches that offer promise for prevention in the FDC context

• Select four FDC systems to implement identified parent training practices

• Administer sub-awards to selected FDC systems to implement parent training and therapeutic services for children as needed

• Provide intensive Training and Technical Assistance to support systemic change and sustain effective parent training

• Develop a realist evaluation strategy to support program development, improvement and the dissemination of findings within and beyond the FDC community
Opportunity for Collaboration with other DDCF grantees

• Each year the Chapin Hall Center at the Univ. of Chicago supports 15 Child Well-Being Fellows with 2-year awards that are designed to create a new generation of leaders who can help create initiatives that can effectively respond to the changing nature of families and to changes within the policy context.

• See the link below for more information: http://www.chapinhall.org/fellowships/doris-duke-fellowships
Other Collaborative Opportunities

- DDCF also supports the work of Dr. Jack Shonkoff and his colleagues at the Center for the Developing Child at Harvard University.
- The Center's mission is to leverage science to enhance child well-being through innovations in policy and practice and to translate advances in neuroscience, molecular biology, genomics, and the behavioral and social sciences into creative, new strategies for action.
- See the link below for more information: http://developingchild.harvard.edu
Collaboration with other Funders

• DDCF is eager to engage other funders in supporting the Prevention and Family Recovery project

• The Duke Endowment in Charlotte, NC is welcomed as a collaborating partner
THANK YOU

Rosemary Chalk, Consultant
rosemary.chalk@gmail.com
PFR Overview

Dr. Nancy Young, Children and Family Futures
PFR Project Partners

• **Children and Family Futures**
  - Providing intensive TA, training and support for grantees
  - Evaluating PFR and disseminating lessons learned

• **Doris Duke Charitable Foundation**
  - Supporting Pima, San Francisco and Tompkins counties

• **The Duke Endowment**
  - Supporting Robeson county

• **PFR National Advisory Council**
  - Providing input and guidance on PFR
  - Providing expert consultation to grantees on key implementation issues

• **The Four PFR Grantees**
PFR Mission

The PFR initiative seeks to demonstrate how a comprehensive family-centered FDC approach—grounded in effective cross-systems collaboration and evidence-based practices—improves child, parent and family outcomes, particularly in the areas of child abuse and neglect, reunification and parent-child relationships.
FOUR INTERSECTING AREAS

SYSTEMS COLLABORATION and IMPROVEMENTS
Facilitate collaboration with the community to meet the needs of families and enable sustainable practice

CHILD DEVELOPMENT/ THERAPEUTIC SERVICES
Improve child well-being by promoting parent/child interaction, physical and developmental health, and social/emotional health

PARENTING SERVICES
Expand parental capacity by improving parenting skills, social skills and coping skills while connecting parents to needed services

TREATMENT
Provide a continuum of comprehensive family-centered treatment services for substance use disorders and other co-occurring conditions
PFR Project Goals

• **Expand the Service Array for FDC Families**
  
  • Integrate proven parenting services and developmental and therapeutic services for children into established FDC programs (with a focus on children 0 to 8 years of age)

• **Improve FDC Capacity**

  • Advance the ability of FDCs to implement, strengthen and sustain more comprehensive family-centered care

  • Facilitate both practice and larger systems improvements for how FDCs and their collaborative partners serve and support families
PFR Project Goals

- **Identify Breakthrough Strategies**
  - Evaluate how a more comprehensive, integrated approach improves family functioning and well-being and prevents child maltreatment
  - Document the conditions that support effective implementation and sustainability of such practices

- **Disseminate Lessons Learned**
  - Foster emerging leaders in the field of prevention, early intervention and treatment for families in FDCs
  - Increase awareness of PFR work and accomplishments
PFR – What Makes You Different

The PFR initiative **IS** about:

- Broader, sustainable systems improvements
- Transforming the way the FDC and its collaborative partners make decisions about policies, programs and allocation of resources, and ultimately serve, support and improve outcomes for families affected by parental substance use disorders

The PFR initiative is **NOT** about:

- A narrowly defined project or single intervention
- Simply adding parenting and child services to the menu of available services for FDC participants
Expectations for PFR Grantees (30,000-foot level)

• Capacity and readiness to engage in a larger systems improvement/change process to provide more comprehensive and integrated family-centered care

• Established (or are willing to establish) a program evaluation infrastructure that routinely tracks key FDC outcomes and other information to systematically improve program performance

• Capacity and willingness to participate in the larger PFR project evaluation
Expectations for PFR Grantees (on-the-ground level)

- Timely PFR implementation – by July 1, 2014
- Monthly progress calls with PFR Change Leader
- FDC team participation in PFR Change Team site visits (total of 6)
- FDC team participation in Grantee Leadership Training Meetings (total of 3)
- Semi-annual Progress Reports (total of 3)
- Final Progress Report
First Grantee Leadership Training Meeting
What We Hope to Achieve

• For the PFR project partners and grantees to get acquainted with each other and build a strong foundational relationship with “the PFR community”

For PFR grantees to:

• Have a clear understanding of the overall expectations and requirements of the PFR grant

• Understand the role of their assigned Change Leader and the National Advisory Council in helping them achieve their PFR goals
First Grantee Leadership Training Meeting

What We Hope to Achieve

• Obtain knowledge about the various technical assistance and training resources available to them

• Understand the PFR evaluation requirements and agree on a common instrument that all sites will use to measure family functioning and well-being

• Develop, in consultation with their Change Leaders, a clear action plan for next steps with their project implementation
PFR Grantee Introductions

Pima County Juvenile Court Center
Robeson County Family Treatment Court
San Francisco Dependency Drug Court
Tompkins County Family Treatment Court
FDC Team And Key Partners

The Team:

• FDC Judge
• Project Director, Program Manager
• Recovery Support Specialist Supervisor
• Two Intake Coordinators
• Four Recovery Support Specialists
• Dedicated DCSFS ongoing unit
• Supervisor, 3 Case Managers, Case Aide
FDC Team And Key Partners

Key Partners:

• Division of Child Safety and Family Services – child welfare
• Terros (Arizona Families First) – parents’ substance abuse treatment
• Community Partnership of Southern Arizona – regional behavioral health authority for adults and children
• Pasadera Behavioral Health – Celebrating Families!
• Easter Seals Blake Foundation – Child Parent Psychotherapy and Incredible Years
• Pima County Public Health Nurses – in-home health and development assessment and service referral
• Arizona’s Children Association/Las Families – individual trauma-focused therapy
Primary PFR Goals

• Develop and demonstrate a model for safe, early reunification
• Demonstrate that using CPS case management in FDC is effective
• Demonstrate that the right support services for families are available in our community
• Strengthen collaboration between adult and children’s providers
• Disseminate results and recommendations for permanent changes
Parenting Services

• Continue Celebrating Families!™
Developmental & Therapeutic Services for Children

- Child Parent Psychotherapy
- Incredible Years/Dinosaur School
- Public Health Nurse home visiting
Our Major Challenges to Overcome

- Support from the bench, children’s attorneys, and Assistant Attorney General for early reunification
- Agreement from children’s Community Service Providers to refer FDC children to the agency providing Child Parent Psychotherapy and Incredible Years/Dinosaur School
- Keeping parents in FDC so that children’s services are not interrupted
- Funding Celebrating Families!™ beyond our current SAMHSA grant
- Coordination of parents’ and children’s services
Key Practice and Systems Improvements We Hope to Achieve

• Use of a Family Recovery Plan in all dependency cases

• Coordination of Children’s and Parents’ services

• Adequate availability and use of Child Parent Psychotherapy, Incredible Years, and Celebrating Families!
FDC Team And Key Partners

- Robeson Health Care Corporation
- Substance Abuse Prevention Services
- Substance Abuse Treatment Services
- Primary and Preventative Healthcare Service
- Robeson County Department of Social Services
- Robeson County Guardian ad Litem
- Parent Attorneys
Primary PFR Goals

- Increase family reunification and positive family relationships
- Promote recovery for substance-involved parents
- Help families overcome trauma-related difficulties
- Create a safe and supportive environment that fosters social, emotional, and behavioral development
Parenting Services

• FDC participants will have the opportunity to receive enhanced parenting services through *Parents as Teachers*, serving families with children ages 0-3, and *Celebrating Families!*, serving families with children ages 3-18.

• In the past, parenting services were provided to families with children ages 6-12 in *Strengthening Families*.
Robeson Health Care Corporation will expand the skills of their clinicians by training them on NCFAS, TF-CBT and Play Therapy. Children in the program will benefit from these expanded services.

Additionally, onsite child care services will be enhanced to include developmental and therapeutic activities to create an environment where children thrive.
Our Major Challenges to Overcome

- Children and adults with providers outside of Robeson Health Care Corporation – these participants can only have one provider and these providers may not be able to provide services such as TF-CBT
- Varying levels of commitment from other providers to participate
- Recruitment and retention of licensed, qualified treatment staff
- Turnover of DSS staff and the need to train/retrain
- Transportation is always a challenge in this rural community
Key Practice and Systems Improvements We Hope to Achieve

• To strengthen the services for the children of our FDC participants, which will build capacity for expanded services to all child welfare involved families

• A coordinated approach among key partners in order to provide the best possible services to parents and children, not only FDC families but the wider child welfare population

• Improve collaboration with other treatment providers for the benefit of the greater court and child welfare systems
San Francisco

Jennifer Pasinosky, Project Director
FDC Team And Key Partners

- San Francisco Superior Court
- Department of Public Health
- Human Services Agency
- Homeless Prenatal Program
- Infant Parent Program
- HealthRIGHT 360
- Hamilton Family Center
- Salvation Army Harbor House
Primary PFR Goals

• Ensure all children receive timely assessments, prompt access to services, and highly coordinated care

• Provide in-home parenting education (SafeCare) to all parents reunifying with children 0-5 years old

• Improve cross-systems collaboration between court, child welfare, family-based treatment, and legal practitioners

• Increase DDC capacity by 25%
Parenting Services

- Triple P – Positive Parenting Program
- Incredible Years
- Nurturing Families
- SafeCare (PFR)
Developmental & Therapeutic Services for Children

• Therapeutic Visitation
• Parent-child psychotherapy
• Child therapy
• Golden Gate Regional Center
Our Major Challenges to Overcome

• Increased and more consistent participation in DDC’s collaborative process among Protective Services Workers and dependency attorneys

• Allocating court resources to expand DDC capacity (e.g. judge time, courtroom space)

• Demonstrating systemic efficiencies and positive impacts on court processes to increase support for DDC operations
Key Practice and Systems Improvements We Hope to Achieve

• Providing more integrated family service planning through a “One Family One Plan” model

• Providing evidence-based, in-home parenting education to all eligible families (children 0-5)

• Developing collaborative procedures to ensure inter-agency communication, role clarification, and comprehensive family support
Tompkins
Patricia Carey, Project Director
FDC Team And Key Partners

- Court
- Department of Social Services (Child Welfare)
- Cayuga Addiction and Recovery Services
- Alcohol and Drug Council of Tompkins County
- Human Service Coalition
- Health Department Early Intervention
- Cornell Cooperative Extension
- Child Development Council
- Tompkins Community Action
- Parent Respondent Attorneys, Attorney for Children
Primary PFR Goals

• Improve communication and collaboration between the FTC Team and parenting skills and child development agencies

• Improve systems for service referrals, linkages, and follow-up with parenting skills and child development services for FTC participants

• Improve available interventions to address the parenting skills and child development needs of FTC participants and their families

• Improve the integration of parenting skills, child development, and substance abuse treatment information in work with FTC participants
**FDC Parenting Services**

- **EXISTING - The Teen Pregnancy/Parenting Program (TP3):** Home visiting services to teens through the age of 21 years. TP3 provides prenatal, parenting, and child development education to youth.

- **EXISTING - Family Support Services (FSS):** This home visiting program encourages parents to identify resources and supports to help them achieve success and reach self-sufficiency. A comprehensive approach includes all family members’ needs, teaching parents about the developmental needs of their children with particular attention to early attachments and guiding parents in positive parenting strategies.
FTC Parenting Services

- **EXISTING - Parenting Skills Workshop Series (PSWS):** FTC refers parents to these parenting skills workshops. The core workshop series is eight sessions, 16 hours and uses a well-tested, evidence-informed curriculum.

- **EXISTING - Parenting Skills Facilitated Family Visits:** Through home visiting, a parenting educator provides one-on-one guidance on ways for parents and children to interact positively with one another. Parents agree to participate in twelve two-hour visits and three one-hour goal setting meetings, but the length of the program is geared to meet parents’ needs.
FTC Parenting Services

- **NEW - Parent-Child Services Coordinator:** Position will develop systems for assessment, service referral, and linkage and follow-up with regard to parenting skills services

- **NEW - Strengthening Families Program:** Evidence-based program developed for families with parental substance abuse to support improvements in parenting skills and overall family functioning

- **ENHANCEMENT - SafeCare Home Visitation Coaching:** Evidence-based home visitation coaching model designed to improve parenting skills in areas of home safety, child health, and parent-child interactions
Developmental and Therapeutic Services for Children

- **EXISTING - Early Intervention Program**: Provides comprehensive developmental evaluation for children ages 0-3. Services include further evaluation if needed, vision and hearing, speech, physical, and other therapies, child development groups, and family counseling. Tompkins DSS requires that all children under 3 placed in foster care receive an evaluation through Early Intervention.

- **EXISTING - Teen Pregnancy and Parenting Program and Family Support Services**: CDC workers regularly conduct the Ages and Stages Questionnaire (ASQ). When potential deficits are identified, children are referred to the Early Intervention Program for more comprehensive assessment and referral to services. CDC staff work to provide parents with information they need to understand their child’s development and develop goals to support healthy development.
Developmental and Therapeutic Services for Children

• **EXISTING - Early Head Start**: Early Head Start serves parents with infants, toddlers, pregnant women, and their families. Program staff includes professionals in the fields of child development, special services, health/nutrition, and mental health. In addition to home visits, EHS provides a safe classroom environment for children while their parents are attending treatment appointments.

• **NEW - Parent-Child Services Coordinator**: Position will develop systems for assessment, service referral, and linkage and follow-up with regard to children’s services.
Our Major Challenges to Overcome

• Changing FTC Team Case Review structure and time-management to integrate information about children into discussions and decision-making

• Integrating trauma-informed care practice throughout the entire system (FTC Team and Agency Partners)

• Improving communication and connection between child and parent services partners

• Maintaining a strengths-based, solution-focused approach with participants, within the FTC Team and between partners

• Creating culture changes needed in FTC Team, Treatment, Child and Parent Services agencies to consistently address substance abuse, parenting, and child development issues concurrently
Key Practice and Systems Improvements We Hope to Achieve

• Consistent coordination and collaboration between substance abuse treatment, parent and children service agencies, and the FTC Team

• A family-based recovery approach is fully integrated within FTC Team discussions, substance abuse treatment, and parent and children services

• Trauma-informed care is practiced authentically and consistently throughout entire system (FTC Team and Partner Agencies)
Grantee Cross-Cutting Issues and PFR Technical Assistance Strategy to Address those Issues

Dr. Nancy Young, CFF
Phil Breitenbuchar, CFF
Why Cross-Cutting Themes?

• We heard issues that came up in all or nearly all of your sites

• We chose your sites because you were making progress — and also because you recognized some of your challenges. Our format is “good news, but…”

• So our responsibility is to continue an honest, candid dialogue about your progress and challenges

• You are not dozens of “freshmen” who are just starting out — the four of you are at the graduate level of our field, and we share a responsibility to frame and extract lessons for the wider field
Overarching Points:

• Your primary goals and desired systems improvements are also your greatest challenges (e.g., a wider array of services demands deeper connections among agencies to track both clients’ progress and agency partners’ results)

• The major challenges you identified span the client, partner and systems levels and affect several key areas of collaborative practice
Cross-Cutting Themes

• All sites are “resource rich” in their partners and services …
  • But need assistance in coordinating and integrating all the pieces
  • A recurring issue on site was “where is the glue?” and “who pulls this together?”

• All sites have strong core FDC teams …
  • But some agencies outside the project may need stronger links and buy-in to become true partners who share resources and outcomes
Cross-Cutting Themes

• All sites embrace the importance of a family-centered FDC approach ...
  • But achieving an effective balance between parent-focused services and child-focused services demands addressing the practices and culture of the FDC and its key partners

• All sites are committed to continuous quality improvements to effectively serve FDC families ...
  • But face challenges with how to track and monitor the effectiveness of some of the other services that FDC families are referred and connected to
Cross-Cutting Themes

• All sites are leveraging existing early intervention infrastructures (e.g., Public Health Nurses or Maternal and Child Health) to help serve young children ages 0-5 ...
  
  • But the issue of which families and parents these agencies serve vs. those that are screened out needs attention within the FDC collaborative

  • Substance abuse can be a systems barrier if it is seen as a risk factor for “other agencies” to deal with
Cross-Cutting Themes

• All sites have been resourceful in mobilizing external and local resources to support collaborative structures and practices ...

• But sustainability planning still often focuses more on continuing grants, with not enough emphasis on institutional funding and institutional changes that redirect funding based on solid outcomes and cost data
Cross-Cutting Themes

• Sites have addressed issues of scale ...
  • But the issues of percentage of total need and projections of costs and savings have not yet framed system-wide choices about whether FDCs are a priority reform or a project dependent on external funding
PFR Change Team – Your Partner in the Process

- **Dedicated Senior-level Change Leader:**
  - Highly experienced in collaborative practice
  - Skilled in facilitating systems improvements & change

- **National Advisory Council (NAC)**
  - Nationally recognized experts in child welfare, family courts, child development, parenting and family functioning, family-centered substance abuse treatment, sustainability and systems change
  - Available to provide site-specific technical assistance

- **PFR Evaluators**
  - Skilled in outcomes and process evaluation
  - Ready to help sites build their evaluation capacity
What to Expect from Your PFR Change Team

Monthly Progress Calls

• Raise implementation or other challenges
• Troubleshoot and identify immediate technical assistance needs
• Celebrate successes
• Facilitate the documentation of process implementation steps and other qualitative data to tell the PFR story
Building the PFR Change Team-Grantee Relationship

Site Visits

• Understand the local community context
• Address any project implementation and staffing challenges, particularly in the areas of cross-systems collaboration and fidelity to evidence-based practices
• Help advance sustainability planning and systems improvements
• Conduct PFR process evaluation activities
Facilitating Peer Networking

• The PFR Project Team seeks to promote peer networking – and we need your input on this moving forward

• Strategies might include:
  • Sharing of resources via the PFR website
  • PFR blog
  • Discussion boards
  • Email groups
  • Newsletters
Available TA Resources
(In addition to your PFR Change Team)

Full complement of TA resources available through Children and Family Futures

• Collaborative practice and policy tools
• Information and sharing of models
• Monographs on key topics
• Training resources and materials
• FDC Learning Academy webinars
• Additional expert consultation and research
How Sites will Benefit

In short, PFR activities will:

- **Support:** The sharing of experiential and research-based knowledge about effective parenting practices with child developmental/therapeutic services for FDC families

- **Build:** The infrastructure needed to integrate these new, enhanced or expanded services into the larger FDC systems of care

- **Advance:** Cross-systems collaborative capacity and leadership to carry out systems improvements focused on strengthening families and serving children in need

- **Sustain:** A system of comprehensive family-centered care that promotes and maintains positive family outcomes
PFR National Advisory Council (NAC)

Who We Are and How We Can Help You
NAC Introductions

• Dr. Vivian Brown, Founder and former CEO of PROTOTYPES
• Carson Fox, National Association of Drug Court Professionals (NADCP)
• Lucy Hudson, ZERO TO THREE
• Dr. Lynne Katz, University of Miami, Linda Ray Intervention Center
• Dr. Sherri Green, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill
• Honorable Nicolette Pach (ret), Suffolk County Court, New York
NAC Introductions
(those who could not join us today)

- **Dr. Rick Barth**, University of Maryland, School of Social Work
- **Dr. Jody Brook**, University of Kansas, School of Social Welfare
- **Dr. Douglas Marlowe**, National Association of Drug Court Professionals (NADCP)
- **Dr. Jennifer Pabustan-Claar**, Riverside County Department of Public Social Services
- **Cambria Rose Walsh**, California Evidence-Based Clearinghouse for Child Welfare (CEBC)
- **Jodi Whiteman**, ZERO TO THREE
- **Honorable Erica Yew**, Santa Clara County Family Wellness Court
Cross-Systems Communication

Dr. Nancy Young, CFF

Presentation will begin at 12:30 pm
Why is Cross-Systems Communication and Coordination so Important?

• Children and families affected by child maltreatment and substance use disorders need help from more than one system

• A wealth of research underscores the need for early identification, intervention and a comprehensive family-centered response
  • Science of early childhood and brain development
  • Effects of parental substance exposure on children
  • Effects of children being removed from their homes
  • Association between adverse childhood experiences and adult substance abuse and mental health issues
Why do Systems Need to Communicate and Coordinate?

• To improve and enhance the collective systems’ response to meeting families’ needs

• To more effectively identify, engage and retain families

• To establish agreement on and shared accountability among system partners for improving families’ outcomes

• To provide formal processes for assessing the collaborative’s progress and addressing policy and practice challenges as they arise

• To help leverage and maximize the use all available resources

• To develop and sustain an integrated, coordinated approach to serving the whole family
Who are “the Systems”?

• Have tended to focus on the three “core” systems: child welfare, substance abuse treatment and family courts.

• PFR expands “the core” – brings in other key service systems that provide parenting and children’s services.

• Makes the issue of cross-systems communication and coordination that much more important . . . And challenging.
Barriers to Effective Cross-Systems Communication

- Discipline-specific Training
- Legal Mandates and Administrative Codes
- Lack of Trust Between the Systems
- Competing Timelines
- Caseload Volume
- Confidentiality Provisions
Key Steps to Building an Effective Communication Infrastructure

- Establish individual and cross-system roles and responsibilities
- Establish joint policies for information sharing
- Develop integrated case plans
- Develop shared indicators of progress
- Monitor progress and evaluate outcomes
Building Cross-System Collaboration: Developing the Structure to Create and Sustain Change

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**FDC STRUCTURE**

- **Membership**
- **Meets**
- **Primary Function:** Information Sharing and Data Systems

**Oversight/Advisory Committee**

- **Director Level**
- **Quarterly**
- **Program Funder:** Ensure long-term sustainability

**Steering Committee**

- **Management Level**
- **Monthly or Bi-Weekly**
- **Policy-Maker:** Remove barriers to ensure program success

**FDC Treatment Team**

- **Front-line Staff**
- **Weekly**
- **Staff Cases:** Ensure client success
Understanding Current Operations

Partners need an in-depth understanding of each other’s systems and how they impact each other

- How does that affect the families you serve?

In developing this understanding, partners:

- Raise awareness about unknown processes
- Clarify misunderstood processes
- Develop a shared, common language
- Identify opportunities for improvements
Systems Walk-Through – A Tool to Increase Understanding

What is it?
• A virtual or actual client walk-through of current systems processes to capture all actions, tools, decisions and data points from referral to case closure to follow up

Why do it?
• To identify any problems with, for example, referrals, treatment access, service gaps, client retention, follow-up support, communication
• To generate recommendations to improve system processes and increase coordination
• To prioritize issues and develop a scope of work
Assessment is a Process

Assessment happens along a continuum to determine:

• **Presence and Immediacy**
  • Is there an issue present?
  • What is the immediacy of the issue?

• **Nature and Extent**
  • What is the nature of the issue?
  • What is the extent of the issue?

• **Developing & Monitoring Change, Transitions & Outcomes of Treatment and Case Plans**
  • What is the response to the issue?
  • Are there demonstrable changes in the issue?
  • Is the family ready for transition?
  • Did the interventions work?
## Definitions of Terms & Processes

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<td>What is the nature of the issue?</td>
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Assessment Information Must be Communicated

Assessment happens along a continuum to determine:

- **Presence and Immediacy**
  - Is there an issue present?
  - What is the immediacy of the issue?

- **Nature and Extent**
  - What is the nature of the issue?
  - What is the extent of the issue?

- **Developing & Monitoring Change, Transitions & Outcomes of Treatment and Case Plans**
  - What is the response to the issue?
  - Are there demonstrable changes in the issue?
  - Is the family ready for transition?
  - Did the interventions work?
The SAFERR Model Development

Builds Cross-System Collaboration

Establishes Individual and Cross-System Roles and Responsibilities

Identifies Front-Line Collaborative Practice

Establishes and Monitors Individual and Cross-System Outcomes
Pathways of Communication Template

Identification Through Community or Family Awareness of Signs, Symptoms and Behaviors

Other Community Agencies
- Screening

Alcohol and Drug Services
- Screen
- Immediate Need Triage
- Diagnosis
- Multidimensional Assessment
- Treatment Plan and Services
- Treatment Monitoring and Transition Planning
- Recovery Management
- Outcome Monitoring

Child Welfare Services
- Child Abuse Report
- In-person Safety Assessment
- In-person Response/Risk Assessment
- Family Assessment
- Case Plan Development and Services
- Case Plan Monitoring, Permanency Determination
- Family Well Being
- Outcome Monitoring

Dependency Court
- Detention/Shelter Hearing
- Jurisdiction Disposition Hearings
  - Review Hearings
  - Family Treatment Court Hearings
  - Case Closures
- Outcome Monitoring
Pathways of Communication Template
for Determining Presence and Immediacy of an Issue

Identification Through Community or Family Awareness of Signs, Symptoms and Behaviors
Family and Extended Family Members

Other Community Agencies
- Observation or Awareness of Child's:
  - Injury
  - Lack of Medical Care
  - Sexual Abuse
  - Inadequate Education
  - Neglect
  - Excessive Punishment
  - Lack of Food
  - Harsh Treatment
  - Other Service Needs

Screening

Community Based Family Support Services

Alcohol and Drug Services
- Screen
- Immediate Need Triage
- Diagnosis
- Multidimensional Assessment
- Treatment Plan and Services
- Treatment Monitoring and Transition Planning
- Recovery Management
- Outcome Monitoring

Results of AOD Screen and Observations of the Following by Parent or Other Individuals in the Home:
- Paraphernalia
- Smell of Alcohol or Drugs
- Slurred Speech
- Lack of Mental Focus
- Off Balance
- Needle Tracks
- Skin Abscesses
- Lip Burns
- Nausea
- Euphoria
- Hallucinations
- Slowed Thinking
- Lethargy
- Hyperactive

Child Welfare Services
- Observation or Awareness of Child's:
  - Injury
  - Lack of Medical Care
  - Sexual Abuse
  - Inadequate Education
  - Neglect
  - Excessive Punishment
  - Lack of Food
  - Harsh Treatment
  - Other Service Needs
- Child Abuse Report
- In-person Safety Assessment
- Court Orders
- In-person Response/Risk Assessment
- Family Assessment
- Case Plan Development and Services
- Family Well Being
- Outcome Monitoring

Dependency Court
- Detention/Shelter Hearing

Outcome Monitoring
Collaborative Practice

• SAFERR
• Collaborative Practice Model
• Cross-Systems Collaboration Primer
• Cross-Systems Data Primer

http://www.ncsacw.samhsa.gov/resources
Next Steps

We discussed the basis for effective cross-systems communication...

Grantees will now work in their teams on their systems walk-through and flow charts
Nurturing Successful Parent-Child Relationships:
The Need to Integrate Parenting and Children’s Services into FDC Programs and the Larger Systems

Dr. Lynne Katz, University of Miami, Linda Ray Intervention Center
Lucy Hudson, ZERO TO THREE
Phil Breitenbucher, Children and Family Futures
Services for Families: Parenting Interventions

• One of the leading services provided for biological families in FDCs is some type of parenting intervention.

• Previously these services may not have been as targeted or as intensive as necessary.

• Grantees submitted their plans for expanding or enhancing their existing EBPs.

• Time for the rubber to hit the road!

Court Mandates for Parenting Programs

• For families with open cases of abuse/neglect case plans have always required the successful completion of a parenting program.

• What did the programs look like?

• What do we mean when we seek to strengthen or improve parenting capacity?

• What constitutes successful completion?
Historical Characteristics of Parenting Programs

- Participation measured by number of sessions attended
- Providers collected only parent satisfaction data
- Cookie cutter approach
- Providers developed their own curriculums and assessments
- Didactic parent-only lecture or informal workshop approaches common
What does Evidence Based Mean and Why is it Important?

• The evaluation research shows that the program produces positive results

• The results can be attributed to the program itself rather than other extraneous factors or events

• The evaluation is peer reviewed by experts in the field

• The program is “endorsed” by a federal agency or respected research organization
EBP Parenting Program Goals

- Increase content knowledge of child development
- Increase self-esteem as a sober parent
- Develop realistic expectations of children
- Increase parental empathy towards children
- Reduce use of corporal punishment
- Help parent recognize children’s need for independence
Generalization of Skills

- Parent can incorporate knowledge into daily parenting activities
- Parent can differentiate and provide for developmental needs of each child
- Parent has support system
- Parent understands appropriate parent authority
- Parent supports children’s independence
- Parent has new solutions for guiding behavior with reduced conflict
Getting Started: Critical Questions

- When is a FDC parent ready to start a parenting program?
- What data will help us answer that question?
- Who needs to be at the table for that discussion?
What Essential Information Will Be Needed

• Sobriety status
• Mental health status
• Compliance status with meds
• Reunification is still the goal
• Visitation in place

• Who else has information to share prior to starting?
• Functioning level of parent
• Special needs of any of the children
Why do We Need to Know?

- Maximize the best outcome for the family participating in the program
- Maximize the degree of openness and willingness to engage on part of the parent
- Ensure effective use of resources
- Ensure that the partners working with the parent understand the goals and expectation of the parenting program (SA, MH, CM, Legal)
Monitoring Progress

- Facilitator reports on degrees of engagement with the group and individual participation
- Baseline and post data is evidentiary for CW

- What if parent is not making sufficient progress?
- SA, MH, CW, Parent collaborate to find solutions
- Parent may need different model
“Although C.G. attended the parenting classes, her score on a post-services test led the case manager to conclude that reunification was not a safe option for the child.”
Participant Progress Data

- Collect at baseline and at completion at a minimum
- Consider a holistic assessment protocol – i.e., including parent-child behavioral observations and parent report measures (valid & reliable)
- Monthly status reports to the court to include pre/post assessment data, facilitator notes regarding parent engagement, levels of disclosure, resistance
- Knowledge learned and application of skills
What Do We Need Parenting Assessments to Tell Us?

• To what extent is the program capturing changes in beliefs, habits and improvement of the quality of parent-child interactions pre/post?

• To what extent did the parenting program help increase parent competency, knowledge and skills acquisition and decrease risk factors that brought the case into FDC?

• To what extent are the parents able to integrate skills learned into the daily activities of their lives?
Cross-Systems Integration

• Outline roles of the partners and schedule frequency of cross-systems check-ins
• What information can flow to and from parenting provider from treatment, case management, legal?
• Client level data collection plan in place
• Cost data of implementation should be tracked (e.g., logs of time and actual effort spent for a one-week window period)
Connecting Parenting and Children’s Services

• Parenting program is not considered a child service
• Parenting program can include parent-child interactive time, but this should not be considered visitation
• Child development information needs to be shared with the parent and the parenting facilitator in advance
• Additional resources may be needed for parent of special needs child (i.e. autism centers)
Understanding Child Development: Relationships are Key

• Babies develop their view of the world (as a welcoming or hostile place) through their relationships with their primary caregivers.

• Predictable routines help babies learn to regulate their behavior.

• Babies need a safe harbor to return to as they begin to explore the world.
Routine Developmental Screening

- Screening at regular intervals (following EPSDT periodicity schedule)
- Opportunity for parents to demonstrate their expertise as parents and to learn more about their child’s strengths and challenges
- Reinforcement of professionals’ knowledge about normal growth and development
It is rarely the case that a maltreated infant has no symptomatology.

Larrieu, J. (2002). Institute of Infant and Early Childhood Development, Tulane University Medical Center
Signs that a Baby’s Emotional Needs Are Not Met

• Sad affect
• Lack of eye contact
• Weight loss
• Lack of responsiveness
• Sensory processing problems
• Rejects being held or touched
Signs of Emotional Problems in 3- to 5-year olds

- Very aggressive behavior
- Attentional problems and deficits
- Lack of attachment
- Sleep problems or disorders
Addressing Developmental Delays

Part C of the Individuals with Disabilities Education Act (IDEA)

Amendments to the Child Abuse and Prevention Treatment Act (CAPTA) in 2003 and 2010: all children under age three who are involved in a substantiated incident of abuse or neglect are referred to Part C services.

The IDEA amendments of 2004 require Part C services for all children who have been maltreated or exposed to prenatal substance use or domestic violence.
Every State has a Part C Sponsoring Agency

- Public Health
- Public School System

And its own name:
- Early Steps
- First Steps
- Early Access
- Birth to Three
- Early Development Network
- First Connections

The Early Childhood Technical Assistance Center has a listing of state Part C Coordinators:

http://ectacenter.org/contact/ptccoord.asp
Increased and Expedited Services for Young Children with Developmental Delays

- Family training, counseling, and home visits
- Nursing, health, and nutrition services
- Service coordination
- Medical services for diagnostic or evaluation purposes
- Occupational and physical therapy
- Psychological and social work services
- Vision, orientation and mobility services
- Speech-language pathology services
- Transportation services
- Age-appropriate special education instruction
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

<table>
<thead>
<tr>
<th>Early</th>
<th>Identifying problems early, starting at birth</th>
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<tbody>
<tr>
<td>Periodic</td>
<td>Checking children's health at periodic, age-appropriate intervals</td>
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<tr>
<td>Screening</td>
<td>Doing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Performing diagnostic tests to follow up when a risk is identified, and</td>
</tr>
<tr>
<td>Treatment</td>
<td>Treating the problems found.</td>
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Copyright © 2010 by ZERO TO THREE
Children from birth to five:

• Newborns can’t suck.
• Misdiagnosed as failure to thrive.
• Significantly delayed developmental milestones.
• Constant ear infections which can lead to partial or total hearing loss.
• Prone to temper tantrums.
Why is Early Diagnosis Important?

Early Diagnosis (before age 6):

- Helps the child receive appropriate services.
- Prevents misguided attempts to address the symptoms with medication and tough love.
- Provides better self-awareness and understanding by family members.
- Prevents secondary disabilities.
Case Plans Should Include:

- Complete health examination for children and parents.
- Exploration of both the parent’s and child’s eligibility for services from the state developmental disabilities agency.
- FASD diagnostic work up for parents and children.
- Completion of high quality substance abuse treatment services is an optimal intervention strategy.
  - If parents are unable to complete the treatment program and maintain their sobriety it is unlikely the home environment is going to be acceptable.
  - Special consideration should be given to the needs of FASD victims in treatment. They don’t do well in group therapy because they cannot follow the discussion. They need to have information reinterpreted for them which requires a one-to-one interaction.
Case Plans Should Include:

- Assessments early in a child’s stay in foster care.
  - Because behavioral issues are very likely, early diagnosis will help prevent multiple foster home placements, a common and serious problem in our current system of care for these children.

- Plan for accomplishing tasks of daily living.
  - Because of the parent’s impaired self-regulatory and cognitive abilities, they cannot create or follow a plan without close supervision.
  - Identify someone who can serve as the parent’s “external brain.” During the life of the case, this external brain could be a shared responsibility of the group involved in family team meetings. Other family members or friends, in-home service providers, mental health clinicians, primary health care providers, and the parent’s attorney are all important members of the team working with the parent.
Triumph Through the Challenges of FAS

Double ARC
3837 Secor Road
Toledo, Ohio 43623
419-479-3060
http://www.doublearc.org/
Visits should occur:

• frequently
• for an appropriate period of time
• in a comfortable and safe setting
• with therapeutic supervision
Children Need to Spend Time with Their Parents

- Involve parents in the child’s appointments with doctors and therapists.
- Expect foster parents to participate in visits.
- Help parents plan visits ahead of time.
- Enlist natural community settings as visitation locations (e.g. family resource centers).
- Limit the child’s exposure to adults with whom they have a comfortable relationship.
Key Questions to Ask Each Month

For all children:
• Is the child getting regular and complete medical screenings? Are the parents participating in appointments?
• Did the Part C screening take place? What were the results? If no services, how are we monitoring the child’s development to ensure that another screening is requested if symptoms of delay emerge?
• What do the other partners working this case say about how well things are going?
• Are new needs emerging that may require a change in services?

For children in out-of-home care:
• Are the parents and child seeing each other multiple times each week? Who is providing supervision? What does the parent have to say about the time s/he is spending with her/his child?
• How is the relationship between the child and foster parent? What does the foster parent say? Does the interaction between them appear comfortable and warm? Is the foster parent supportive of the birth parent’s relationship with her/his child?
FDC Participant Questions Regarding Relationship with Child (depending on age):

1. How does your child like to be held?
2. How does your child react to strangers?
3. How does your child react when he/she sees a new person?
4. How does your child react when you arrive for your visit?
5. How does your child react when you leave the room after your visit?
6. When your child gets hurt, who does he or she want comfort from? How do you comfort your child?
7. Name one thing in the past week that you did with your child that made you feel good about being a parent?
Facilitated Discussion - Integrating Parenting and Child Services
Questions for Grantee Team Work

• Which key partners do you need to share parenting and children’s services information with and why?

• Can you map the flow of families from one agency to another?
  • Are you able to create a diagram that shows how many estimated children and parents move from one agency's caseload to another?

• What are the essential pieces of information you need to document and when? How might you do that?
  • Look back at your Systems Walk-Through to identify key data collection and sharing points
Questions for Grantee Team Work

• How can you use that essential information to engage parents/families in treatment?

• What about to engage other service providers in providing a comprehensive family-centered approach?

• What are the major challenges/barriers you face in integrating parenting and children’s services into the FDC program? What about into the larger systems?
What Do We Mean by Systems Change?

Escaping from Project Thinking

Sid Gardner, Children and Family Futures
"Systems change is a process that shifts the way that an organization or community makes decisions about policies, programs, and the allocation of its resources – and, ultimately, in the way it delivers services and supports its citizens and constituencies."

-National Association of Councils on Developmental Disabilities
Where does the FDC fit in the larger system?

Most sit on top

Or on the side
Part of a Greater Whole

Embedded Integrated Institutionalized

Community

Child Welfare & Other Agencies

FDC

Project

Family

Child

Project in Environment
Being Part of the System Means

• Knowing the extent which the FDC meets the larger child welfare, substance abuse treatment and other agencies’ needs
  • **Penetration rate, scale**
• Knowing how the FDC complements other child welfare, substance abuse treatment and related community initiatives in deciding who they serve
  • **Parallel initiatives, target**
Being Part of the System Means

• Understanding – and then planning to reduce – system-wide barriers in the court, child welfare, treatment and other agencies that affect families’ outcomes
  • **Barrier and drop-off analyses**

• Knowing how the FDC affects outcomes for the court, child welfare, substance abuse treatment and other agencies

• Knowing how resources will be shared, redirected and leveraged across systems
  • **Institutionalization**
Institutionalization

- Taking an FDC practice and making it a permanent feature in the existing systems of care
- Doing something new or doing an established practice in a new way that is better than the old way
- Becoming an accepted part of training programs, agency budgets, protocols that extend across the organization (vs. for a small segment of the caseload)
- Linking the FDC with parallel reforms in the rest of the agency
A Different Lens – Paradigm Shift

You can’t have an effective FDC if systems changes are not made.

All you have is an isolated project.
Project Thinking vs. Systems Thinking
<table>
<thead>
<tr>
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<th><strong>Systems Thinking</strong></th>
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<tbody>
<tr>
<td>Focus on single project, single grant</td>
<td>Awareness and identification of larger system, its resources and needs</td>
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<tr>
<td></td>
<td>Inventory of multiple funding streams</td>
</tr>
<tr>
<td>Key resource = one time grant funding</td>
<td>Selects best targets among funding streams that are institutionalized</td>
</tr>
<tr>
<td>Sustainability = grant award</td>
<td>Key baseline measures are used to assess project’s outcomes against those of larger system</td>
</tr>
<tr>
<td>Outcomes measured by performance of project for its clients</td>
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<tr>
<td>Project Thinking</td>
<td>Systems Thinking</td>
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</tr>
<tr>
<td>Process measures for project are important aims</td>
<td>Process measures are justified by positive impact and whether they lead to new ways of doing business and better results</td>
</tr>
<tr>
<td>Project proposal guides implementation</td>
<td>Awareness of key barriers affecting replication and outcomes of clients who could be served by larger project</td>
</tr>
<tr>
<td>Leadership focuses on project</td>
<td>Leadership is capable of systems thinking and has effective working relations in larger system</td>
</tr>
<tr>
<td>Project elements make up framework of analysis</td>
<td>Larger framework used to consider barriers and develop strategic responses</td>
</tr>
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<td>Project Thinking</td>
<td>Systems Thinking</td>
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</tr>
<tr>
<td>Rules of agency procedures are taken as given</td>
<td>Documenting and changing the rules that form barriers are major goals of project</td>
</tr>
<tr>
<td>Project environment includes policies of funding agency</td>
<td>Policy environment is monitored and updated as it is likely affect replication and institutionalization</td>
</tr>
<tr>
<td>Project staff view those served by the project as the relevant universe of clients</td>
<td>Project staff aware of what % of total need project is being served and understand their “market share”</td>
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</table>
What does Systems Change have to do with Sustainability?

• If the project is worth sustaining — the issue is what gets sustained besides just keeping the project alive?

• Is scaling up the project being addressed?

• Are institutional changes on the table? Did anyone in the larger systems adopt your new ways of doing things?

• Are new or redirected funding streams being discussed in ways that represent systems change – e.g., Medicaid waivers, IV-E waivers, new revenue sources, new social finance approaches?
FDCs are typically a marginal reform
- They usually meet 5-10% of the total need

If augmented FDCs are effective, why not scale them up or infuse their practices in the larger system?

A model project’s goals must go beyond sustaining the project to scaling it up, replicating its effectiveness, redirecting funding, finding new revenue sources, and infusing its practices in the rest of the system.
- Otherwise it’s just an isolated project: a diamond in a dime store.
Ten Elements of Collaborative Practice

Mission

1. Underlying Values and Priorities

Children, Family, Tribal, and Community Services

2. Screening and Assessment
3. Engagement and Retention
4. Services for Children
5. Community and Family Supports

System Elements

6. Information Systems
7. Training and System Tools
8. Budget and Sustainability
9. Working with Other Agencies

Outcomes

10. Shared Outcomes and Systems Reforms
Assessing Capacity for Systems Change

Shared Outcomes

Agency Collaboration
- Interagency Partnerships
- Information Sharing
- Cross System Knowledge
- Funding & Sustainability

Client Services
- Early Identification & Assessment
- Needs of Adults
- Needs of Children
- Community Support

Shared Mission & Vision
Assessing Capacity for Systems Change – The Four Stages of Collaboration

Information Exchange

Joint Projects

Changing the Rules

Changing the System

Better outcomes for children and families

Redirection of funding

Shared data
Universal screening
Shared case plans

External $$ here

Existing $$ here

Sid Gardner, 1996
Beyond Collaboration to Results
Systems Change – Common Features

• Goes **beyond the boundaries** of the project
• About both systems and **clients – how they move through the system** and what happens afterwards
• Requires a **continuous feedback loop** provided by information systems
• Takes place in a **learning organization** that is open to feedback from partners, clients and the wider community
Systems Change – Common Features

- Accepts that **funding and staffing resources** are critical for institutional change
- **Sustainability** is addressed on a continual basis – **outcomes and cost savings** drive decisions
- **Barriers** are not accepted — partners share information about institutional barriers and see them as targets for change
- **Strong leadership** exists at all levels
Clues to Systems Change Issues

• “The regulations/guidelines/policy won’t let us do that”
• “How could we ever get caseloads that low?”
• “How could we get a grant to do it that way?”
• “The feds don’t require that”
• “We can’t get the data we need from the agency to track clients’ outcomes over time”
• “We don’t have the training to do that”
Leadership that Moves Projects to 
Systems Change

• Does not “just happen”
• Demands a set of competencies and perspectives based 
on a leader’s past experience and orientation to future possibilities
• Above all, requires an ability to balance and blend approaches that don’t always go together:
  • Inside-outside: the project and its partners
  • Client perspectives and front-line staff outlooks
  • Current funders’ mandates and future funders’ needs
  • Operations and results: What the agency is doing and how children and families are doing
  • Understanding barriers and rules and knowing when and how to challenge and change them
  • Feasible start-up scale of operations and the tasks of scaling up
The Leadership Thing

Some are leaders by definition: they were elected or appointed, they have formal leadership roles in courts and agencies. Some of them may believe they have nothing to learn about leadership because they are defined as leaders already.

Some, however, are leaders by destination: they are leaders in going beyond the project’s boundaries:

• Leaders of a boutique; island-dwellers happy to be separated from the mainland?
• Leaders of a movement that is defined by its mission, not its titles
• Leaders who can persevere in pressing for institutional change
• Leaders in mobilizing resources in agencies they don’t control, in bringing in new dance partners or always dancing with the same people?
• Leaders who export their successes — vs those happy on their own islands
• Leaders in judging agency performance as well as parents’ performance; are agencies making reasonable efforts
Common Barriers to Systems Change – Examples

• Small caseloads in projects:
  • How to replicate in the larger system?
• Family drug court scale averages 54 clients:
  • How to expand to other courts and more clients?
• Inadequate Medicaid coverage for treatment:
  • Medicaid waivers
• Early care and education slots for clients’ children:
  • Negotiations with Head Start
• Referrals to treatment agencies:
  • Monitoring treatment outcomes – beyond “case management” to tracking real outcomes
Systems-level Questions
How can innovative projects help answer these?

• Can child welfare achieve its mandated goals within the child welfare system—or are resources from other systems critical to success?

• Can evidence-based child-parent programs replace widely used sub-standard parenting programs?

• If most treatment programs don’t meet federal agencies’ standards for effectiveness—why are they still funded? Why do courts refer to them?

• Are “reasonable efforts” ever adequate if they ignore reasonable standards for effectiveness?
How Can We Move Towards Systems Thinking?
Discussion Questions for Grantee Team Work

• What does systems change mean to our team?
• What kinds of systems improvements and changes would make the most sense for our FDC and our families?
• Where do we see the most opportunity and potential for systems improvements and change?
• How clear are we about the biggest barriers we’ve run into? Which ones are we trying to change? Who could help us do that?
How Can We Move Towards Systems Thinking? Discussion Questions for Grantee Team Work

• Consider the leadership qualities that were outlined. Are these the right ones? What else should we add?
• What do our leaders do best? What is most challenging?
• What is our balance now between project focus and systems focus: 50-50? 90-10?
• To what extent are systems-level issues even on the table? How could they be?
• What are the most important innovations that our FDC has already made that the larger system needs to adopt? How can we begin marketing them?
Thinking Trauma First – Enhancing Court Programs for Children and Families

Dr. Vivian Brown, Founder and Former CEO of PROTOTYPES
Importance of Trauma-Informed (TI) Services in Drug Courts

- High prevalence of trauma, substance abuse and mental health disorders in FDC populations
- Parents need to understand impact of trauma on them and their children
- Need to reduce possible re-traumatization of parents and children
- TI services improve retention in services
- TI services improve family outcomes, including prevention of child disorders
Definition of Trauma

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.  

(SAMHSA, 2013)
Failure to Identify and Address Trauma

May lead to:

- Withdrawal from services
- Inadequate or inappropriate services
- Re-traumatization
- Increase in relapse events
- Increase in management problems
- Poor treatment outcomes
Responses to Traumatic Events

• **FIGHT** – Individual in court acts in an angry/hostile way

• **FLIGHT** – Individual does not follow court plan or does not return to court

• **FREEZE** – Individual may be unable to communicate (mostly seen in children)

• All of these affect an individual’s response to court and agency requirements

• When you encounter a Fight-Flight-Freeze response, think trauma first
Two Major Studies in Defining Trauma-Informed Practice

• The Adverse Childhood Events (ACE) Study

• Women with Co-Occurring Disorders and Violence Study (WCDVS)
Adverse Childhood Events (ACE) Study

- Kaiser Permanente (Felitti) and CDC (Anda)
- Large-scale epidemiological study of influence of stressful and traumatic childhood experiences
- Interviewed more than 17,000 people
- Investigating adverse childhood experiences and adult health status
ACE Study – Prevalence

• Recurrent and severe physical abuse - 28%
• Recurrent and severe emotional abuse -11%
• Contact sexual abuse - 22%
• Neglect: Physical – 10%; Emotional – 15%

Growing up in a household with:
• Alcoholic or drug-user - 27%
• Member being imprisoned - 6%
• Mentally ill, chronically depressed, or institutionalized member - 19%
• The mother being treated violently - 13%
• Both biological parents NOT present - 23%
ACE Study – Findings

• Scoring system used – one point for each event experienced before age 18
• ACEs not only common, but effects cumulative
• Compared to persons with ACE score of 0, those with a score of 4 or more were:
  • 4.6 times more likely to experience mental health problems (depression), with an even higher rate of attempted suicide
  • 5.5 times more likely to be involved with DV
  • 10 times more likely to have injected street drugs
  • 10 times more likely to have serious and multiple health issues
### Frequency of ACE Items Among Women Who Were in Foster Care as Children

<table>
<thead>
<tr>
<th>ACE Question</th>
<th>Before Foster Care</th>
<th>After Foster Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Physical Abuse</td>
<td>39%</td>
<td>43%</td>
</tr>
<tr>
<td>2. Sexual Abuse</td>
<td>34%</td>
<td>55%</td>
</tr>
<tr>
<td>3. Intimidation</td>
<td>48%</td>
<td>51%</td>
</tr>
<tr>
<td>4. Psychological Abuse</td>
<td>55%</td>
<td>64%</td>
</tr>
<tr>
<td>5. Physical Neglect</td>
<td>46%</td>
<td>30%</td>
</tr>
<tr>
<td>6. Parental Loss</td>
<td>43%</td>
<td>22%</td>
</tr>
<tr>
<td>7. Maternal Abuse</td>
<td>41%</td>
<td>16%</td>
</tr>
<tr>
<td>8. Household Substance Abuse</td>
<td>45%</td>
<td>16%</td>
</tr>
<tr>
<td>9. Household Mental Illness</td>
<td>47%</td>
<td>23%</td>
</tr>
<tr>
<td>10. Household Member in Prison</td>
<td>24%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Bruskas & Tessin, 2013
Changes in Developing Brain Function

TOXIC Stress

Altered Outcomes (Fractured Social Networks, Adoption of Unhealthy Lifestyles, Changes in Immune Function)

Poor Health Outcomes

Childhood Adversity
The Influence of Adverse Childhood Experiences Throughout LifeACE’s Major Determination of Health & Well Being (Felitti, 2003)
Women with Co-Occurring Disorders and Violence Study

• 5-year national study funded by SAMHSA – 9 sites in the country
• 2,729 women enrolled in the study
• 54% White, 18% Latina, 29% African American
• Women had diagnoses of mental illness, substance use disorders, and trauma/violence
• Women were to have 2 previous treatments
• Each site had Intervention and Comparison programs
• 4 sites also studied the women’s children
Lessons Learned from WCDVS

• Services were most effective if they:
  • Integrated trauma-specific interventions, substance use services, and mental health rather than treat these problems separately
  • Used group environments and interventions to help restore trust and promote healing (e.g., Seeking Safety, TREM, Beyond Trauma)
  • Included peers (consumer/survivor/recovering) staff in the planning and delivery of services

• Children’s Subset Study found that 87% of the children witnessed domestic violence
Lessons Learned From WCDVS

• Children’s Subset Study: At 6 months past baseline, the mother’s positive change in symptoms was the strongest predictor of the child’s positive changes

• The two important components of transforming our systems are
  • Trauma-Specific Services
  • Trauma-Informed Practices and Systems
What Does It Mean To Be A Trauma-Informed Court?
Trauma-Informed Courts

• Creating a safe environment is the first priority
• This also requires attention to adequate resources:
  • Adequate staff (including AOD, MH, DV, CW)
  • Sufficient training of all system members
  • Adequate number of programs and interventions
• Creating an environment in which everyone (parents, children, staff) feel safe, supported, respected and engaged
Trauma-Informed Courts

• Court practices and requirements are delivered in ways that avoid triggering trauma memories (re-traumatization)
• Practices support client choice whenever possible
• Court provides clear information about what clients can expect
Re-Traumatization

- Refers to the psychological and physiological experience of being triggered (by a sound, sight, sensation) that recalls the original abuse

- Triggers may include:
  - Strip searches
  - Use of handcuffs or restraints
  - Seeing security personnel with guns
  - Shouting and insults
  - Presence of batterer in the courtroom at same time participant is asked about physical abuse
  - Child removed from abusive home experience.
A Trauma-Informed Family Drug Court

- Routinely screens for trauma exposure
- Provides training/education to children, parents, families and providers on trauma exposure, its impacts and treatments
- Uses culturally appropriate, trauma-specific, evidence-based interventions to strengthen resilience and protective factors of children and families
- Addresses parent and caregiver trauma
- Emphasizes collaboration across service systems
- Maintains an environment of care for staff that addresses/reduces secondary traumatic stress
Principles of Trauma-Informed Care

- **Safety:** Ensure physical and emotional safety and minimize re-traumatization
- **Trustworthiness:** Maximize trust, make tasks clear and maintain appropriate boundaries
- **Choice:** Support participant choice and control whenever possible
- **Collaboration:** Maximize the sharing of power with participants and team members
- **Empowerment:** Emphasize participant skills-building and empowerment

*(Harris & Fallot, 2001)*
Incentives

• Incentives for compliance are quite important

• Adult/parent incentives could include:
  • Bus tokens
  • Phone cards
  • Toiletries
  • Fishbowl Drawings
  • “Dress for Success”

• Child incentives should match the child’s developmental needs and could include:
  • Tummy time mats
  • Educational toys
  • Games for visits
Sanctions

• Sanctions should take into consideration behaviors that were precipitated by the trauma, such as not complying with drug testing because observed testing triggered memories of sexual abuse.

• Sanctions could include: Essay Assignments (or tape recordings if participant has difficulty writing or reading) on Relapse Triggers, Lying & Dishonesty; return to preceding phase; community service.

• If participant is otherwise compliant with treatment and other requirements, but not responding to treatment interventions, make therapeutic adjustments (adjust treatment plan).
Infant Mental Health

• Infant Mental Health is defined as the developing capacity of the infant to:
  • Experience, express and regulate emotions
  • Form close and secure relationships
  • Explore the environment and learn
  • All in the context of cultural expectations

• Mothers with a history of childhood abuse:
  • Are unable to hear their child’s distress
  • Find parenting more stressful
  • Have less effective/less nurturing parenting styles which could lead to harsh and punitive methods
Infant Mental Health

Understanding the role that toxic stress plays in lifelong consequences of childhood adversity highlights important opportunities:

• **Home Visiting** – supports the capacity of mothers to develop strong, responsive early relationships with their children and to alter the child’s trajectory.

• **Changing Behaviors to Prevent Disease** – “unlearning” unhealthy lifestyles (smoking, substance use, etc) through interventions and mentors

• **Evidence-based interventions** – to address trauma

• **Parenting training** – teaches new skills in responding
## Evidence-Based Interventions

<table>
<thead>
<tr>
<th>Child Interventions</th>
<th>Parent/Adult Interventions</th>
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<tbody>
<tr>
<td>Child-Parent Psychotherapy (CPP)</td>
<td>Seeking Safety</td>
</tr>
<tr>
<td>Parent-Child Interaction Therapy (PCIT)</td>
<td>Trauma Recovery and Empowerment (TREM)</td>
</tr>
<tr>
<td>Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)</td>
<td>Beyond Trauma</td>
</tr>
<tr>
<td>Incredible Years</td>
<td>Triple P Parenting Program</td>
</tr>
<tr>
<td></td>
<td>Nurturing Parenting Training</td>
</tr>
</tbody>
</table>
Key Elements of a Family-Centered Trauma-Informed Paradigm

- Family-Centered
- Prevention
- Early Intervention
- Trauma-Informed
<table>
<thead>
<tr>
<th></th>
<th>Contemplation</th>
<th>Preparation</th>
<th>Action</th>
<th>Maintenance</th>
<th>Possible Relapse</th>
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</thead>
<tbody>
<tr>
<td><strong>Pre-contemplation</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Mother</strong></td>
<td>DV</td>
<td>AOD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Father</strong></td>
<td>AOD DV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Child</strong></td>
<td>Witnessing DV</td>
<td></td>
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</tbody>
</table>
Importance of Parenting Training

- Parents need to be encouraged to talk to their babies, even when they do not yet talk back (First 5 LA program – “Talk-Read-Sing”)
- Parents need to be taught to smile at, praise and play with babies in a reciprocal, non-intrusive way.
- Parents need to understand why their toddler is throwing a temper tantrum and develop the strategies needed to effectively handle this normal behavior.
- Parents need to understand and practice routines for times that might be stressful (bedtime, mealtime).

(Katz, Lederman, Osofsky, 2011)
Trauma-Informed Systems
Change and Assessment
Trauma- Informed Assessment for FDC and Partners

- Fallot & Harris (2004) developed an Agency Self-Assessment, involving 5 core elements:
  - Safety
  - Trustworthiness
  - Collaboration
  - Choice
  - Empowerment

- Brown (2008) adapted the Assessment into a System/Agency “Walk-Through” that allows staff and administrators to move through system processes through the eyes of the client
Trauma-Informed Assessment

• Look at each step from first contact with the court to referrals for treatment and other options to identify “triggers” and develop an Action Plan that includes possible solutions for each potential trigger.

• The constant question is: “Could this procedure/step/practice upset or trigger a client?”

• The assessment is a mutual information-gathering strategy that does not feel like a judgment.

• When we look through the “trauma lens,” we understand that we may be unintentionally re-traumatizing clients.
Trauma-Informed Assessment

- Formulation of **Action Plan** includes:
  - Issues - Potential Triggers – Possible Solutions
- The team then spends time expanding possible solutions
- The team implements PDSA cycles (Plan-Do-Study-Act) to test possible solutions on small scale
- Trainings and TA then grow from the Assessment and Action Plan
For More Information

- [www.acestudy.org](www.acestudy.org)
- [www.theannainstitute.org](www.theannainstitute.org)
- Vivian Brown, Ph.D. – [protoceo@aol.com](mailto:protoceo@aol.com)
Discussion Questions for Grantee Team Work

• What are we (the FDC team) doing about screening both the parent and child for trauma?

• Consider the elements of a trauma-informed FDC (refer to slide and handout in your packets).
  • Which elements are you strong on?
  • Which ones do you need to improve?

• To what extent do your parenting and children’s services address trauma?